EDITORIAL

New Developments in Vascular Surgery: A Young Journal Changes its Title

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The technical performance of endovascular surgery has two prerequisites: visualisation of the vascular system; and reliable instrumentation, which allows safe manipulation for treatment within the vascular system. Although the term "endovascular surgery" is fairly new, the start of the endovascular approach probably goes as far back as 1929, when the German surgeon W. Forßmann catheterised himself, to demonstrate visualisation of the pulmonary artery and the right heart.[1] Charles Dotter in 1963 accidentally passed a catheter via the femoral artery through an iliac occlusion to perform an angiogram of the abdominal aorta and after retraction of the catheter the iliac artery stayed open.[2] Today, balloon angioplasty and percutaneous insertion of stents, cava filters and other devices are part of interventional radiology. However, the relevance to vascular surgery of interventional procedures has many aspects:

1. Percutaneously performed endovascular procedures are palliative procedures, which include a more or less high failure rate in comparison to conventional "open" surgical procedures. The prompt repair of failed percutaneous interventional procedures is only possible if a close and efficient collaboration between the interventional radiologist and the vascular surgeon is guaranteed. Otherwise, interventional methods performed by non-vascular surgeons put the patient at enormous risk for the sake of sparing an operation.

2. The multifocal occurrence of stenosis and occlusions in the atherosclerotic patient may be managed with the combined performance of balloon dilatation and open reconstructive procedures simultaneously.

3. In vascular surgery endovascular procedures were used long before balloon angioplasty was developed. The ringstripper of Canon, the ringstripper developed by Vollmar and the Fogarty balloon catheter are well known examples. The ringstripper has proved to be an especially valuable tool, to remove long plaques, which have been dilated and dissected by balloon angioplasty but caused acute occlusion just after. The Fogarty balloon catheter is also a useful tool.

4. The insertion of stents after dilatation has been shown to prevent restenosis. Again, vascular surgery and interventional radiology must work closely together, because if the operation is performed percutaneously uncorrected failures might lead to loss of extremities and organs. In addition, late failures and recurrent disease must be corrected by open conventional reconstructive surgery for acceptable long-term patency.

Therefore, the integration of methods used in interventional radiology into vascular surgery is not a change of occupation to encompass another discipline, rather the adaptation of new methods, which in other forms have been part of reconstructive vascular surgery for many years.

The last step of these technical developments seems to be the endovascular approach to stabilise aneurysms by application of an endoluminal prosthesis fixed by stents or metallic hooks against the wall of the artery proximal and distal to the aneurysm.[3] Although the technical feasibility has been shown for aortic aneurysms in about 100 cases throughout the western world, the procedure is more or less experimental clinical surgery and awaits further validation as an acceptable therapy, when early and long term complications, long time success rate and costs are taken into account. It is not right to ignore these developments because vascular surgeons are not convinced of the success of the new methods. Even today in reconstructive vascular surgery we are using many instruments, procedures and techniques successfully, which were neglected less than 40 years ago, because they were thought to be too dangerous, unethical and without long term success. We must concentrate without prejudgement and on the basis of natural science, especially vascular biology, on evaluating new instrumentations and procedures for the welfare of our patients. "What is wanted is not the will to believe but the wish to find out, which is the exact opposite" (Bertrand Russell, 1872–1970). Therefore "endovascular" is now included in the title of our young journal and the new title of the journal reflects the fast progress in the development of new methods in this field. Perhaps in the future the best person to treat patients with vascular lesions will be the vascular therapist, who may be specialised in either conservative or operative (including endovascular) treatment.

The journal with its new name wishes to serve as the scientific platform, in which the practical and scientific outcome of vascular reconstructive and endovascular methods can be launched in the form of scientific papers, technical descriptions and reports of success and failure rates.

References

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